Welcome to our office

Name _____ Date _____

Street Address _____ Date of Birth _____

City, State, ZIP _____ Occupation _____

Phone Home _____ Work _____ Cell _____

Email Address _____ Vision Plan _____ Medicare # _____

Last Eye Exam Date _____ Previous Eye Dr. _____

Medications Taken _____

Drug Allergies _____

Medical History

Eyes/Vision	YES	NO
Crossed Eyes	Y	N
Lazy Eye	Y	N
Eye Injury	Y	N
Eye Surgery	Y	N
Glaucoma	Y	N
Cataracts	Y	N
Macular Degeneration	Y	N
Floaters	Y	N
Flashes of Light	Y	N

Systemic/Constitutional		
Fatigue	Y	N
Cancer	Y	N

Ear/Nose/Throat		
Allergies/Hay Fever	Y	N
Sinus Problems	Y	N
Chronic Cough	Y	N
Dry Mouth	Y	N

Neurological		
Headaches	Y	N
Migraines	Y	N
Seizures	Y	N
Multiple Sclerosis	Y	N

Psychiatric	YES	NO
Depression	Y	N
Anxiety	Y	N
Bipolar	Y	N
Attention Deficit	Y	N

Cardiovascular		
Hypertension	Y	N
Heart Disease	Y	N
Stroke	Y	N

Respiratory		
Asthma	Y	N
Bronchitis	Y	N
COPD	Y	N
Emphysema	Y	N

Gastrointestinal		
Crohn's Disease	Y	N
Colitis	Y	N
Ulcer	Y	N
Digestive	Y	N

Genitourinary		
Kidney Disease	Y	N
Pregnant	Y	N

Musculoskeletal	YES	NO
Osteoporosis	Y	N
Arthritis	Y	N
Fibromyalgia	Y	N
Gout	Y	N

Integumentary		
Psoriasis	Y	N
Rosacea	Y	N
Eczema	Y	N

Endocrine		
Insulin Dep. Diabetes	Y	N
Non-Insulin Dep. Diabetes	Y	N
Thyroid Disease	Y	N

Lymphatic/Hematological		
High Cholesterol	Y	N
Anemia	Y	N

Allergy/Immunological		
Environmental Allergy	Y	N
Rheumatoid Arthritis	Y	N
Lupus	Y	N
Drug Allergy	Y	N

Family History- has anyone in the patient's family (blood relative) had any of the following?

Cataracts	Y	N	Glaucoma	Y	N	Retinal Disease	Y	N
Crossed Eyes	Y	N	Lazy Eye	Y	N	Macular Degeneration	Y	N
Hypertension	Y	N	Diabetes	Y	N	Heart Disease	Y	N
Cancer	Y	N						

Do you wear glasses? Y N Do you wear contact lenses? Y N

Type of contact lenses ☐ Rigid ☐ Soft ☐ Daily Wear ☐ Overnight Wear

How often do you replace your contact lenses? ☐ Daily ☐ 1-2 Weeks ☐ Monthly ☐ Quarterly ☐ Yearly